MEDICAL RECORDS AFFIDAVIT

STATE OF TEXAS

COUNTY OF DALLAS

Personally appeared before me, the undersigned authority in and for the aforesaid jurisdiction, Will Williams, (or alternatively, Will Williams, Records Custodian), who, upon his/her oath, stated that (1) he/she has first-hand knowledge of the maintenance and/or storage of the attached records; (2) the attached records are a true and correct copy of the medical records that were kept on file in the regular course of the examination, evaluation, and/or treatment of **Gary Brice McBay**, Date of Birth: [redacted], Social Security No.: [redacted]; and (3) the records were generated in the regular course and activities of **Cedars Hospital, Desoto, Texas**, and made at or near the time of the matters set forth by, or from information transmitted by, a person with knowledge of those matters.

I certify the above declaration is true and correct under penalty of perjury.

Will Williams
AFFIANT

Sworn to and subscribed before me, this 19 day of November, 2009.

Mary Cobb
Notary Public

My Commission Expires:
5-5-2012

MARY COBB
NOTARY PUBLIC
State of Texas
Comm. Exp. 05-05-2012

EXHIBIT
"E"

THE CEDARS HOSPITAL

DISCHARGE SUMMARY

PATIENT NAME: Gary McBay
MEDICAL RECORD #: 20991
ADMISSION DATE: 06-05-05
DISCHARGE DATE: 06-07-05
ATTENDING PHYSICIAN: Manoochehr Khatami, M.D.
DICTATED BY: Ray Garcia

INITIAL DIAGNOSIS:
AXIS I: Alcohol dependence.
AXIS II: None.
AXIS III: None.
AXIS IV: Severe.
AXIS V: Current GAF is 35. Highest past year is 50.

DISCHARGE DIAGNOSIS:
AXIS I: Alcohol dependence.
AXIS II: None.
AXIS III: None.
AXIS IV: Economic.
AXIS V: Current GAF is 45. Highest past year is 50.

IDENTIFICATION/REASON FOR ADMISSION: This 28-year-old male was admitted for hospitalization as a result of significant alcohol use, identifying drinking up to a case of beer per day. He indicated deterioration in self-care activities as well as amassing large beer tabs. The patient was identifying impairments in concentration and attention spans, low self-esteem, as well as isolative and withdrawn. He was drinking until he passed out. He was assessed as at high risk for withdrawals as well as unable to maintain abstinent status and therefore admitted for inpatient detoxification and stabilization.

PSYCHIATRIC HISTORY: The patient was indicating previous outpatient trials of Ambien, Zoloft and Paxil with limited response with no other treatment interventions noted.

PHYSICAL STATUS: Medically stable.

LAB EXAMINATIONS: Drug screen results were negative. Ethanol levels below 10. Urinalysis results in range.

HOSPITAL COURSE: The patient was admitted to the inpatient program to address significant alcohol use, impending withdrawals, inability to abstain as well as lack of coping

skills. He was initially placed on close observation status with the patient started on a Valium countdown to address withdrawal symptoms.

He was initially having some difficulties adjusting to treatment milieu, preoccupied with discharge, and wanting to leave treatment. He was encouraged to stay and agreed to do so, especially in light of high relapse potential as well as high risk for withdrawals. He continued to benefit from medication administration in helping to alleviate severity of withdrawal symptoms with vital signs stabilizing. He was encouraged to initiate Step work, as well as encouraged to work on better utilizing external support. The need to work on increasing awareness of the disease process was reinforced with the patient slowly better engaging as well as better aware of his need for treatment. He was indicating plans to pursue sponsorship as well as to pursue 12-Step participation. The patient was able to identify reduction and subsequent cessation of further withdrawal symptoms as well as indicating feeling better about himself and about the future. He was subsequently discharged effective 06/07 to outpatient status.

CONDITION ON DISCHARGE: Somewhat improved. Affect and mood were more stable. He was oriented x 3. Memories for recent and remote events were essentially intact. No overt delusions or hallucinations were noted. Denying any overt suicidal or homicidal thoughts. Insight and judgment had improved.

DISCHARGE MEDICATIONS: None noted.

DISCHARGE/AFTERCARE INSTRUCTIONS: The patient was encouraged to continue with outpatient 12-Step meetings as well as regular sponsor contact.

DIET: As tolerated.

ACTIVITY: As tolerated.

PROGNOSIS: Fair with continued follow up.

Manoochehr Khatami, M.D.
DICTATED BY: Ray Garcia
MK: RG/kc-mv/MT D: 06-06-06 T: 06-06-06 # 01536

PSYC IATRIC EVALUATION FC M

Patient's Name: BRICE McBAY	☒ Male ☐ Female	Age: 28
Date Seen by ~~Physician~~: 6/5/05	Time Seen by Physician: 6:15 pm	Source of Information: Patient	Reliability:

Reason for Admission: "My drinking - I drink way too much."
(Mother wants patient to be here)

Chief Complaint: "I drink too much & I'm tired of it"

Precipitating Stresses: Pressure from mother/father who are supportive and explored Rx options for patient

History of Present Illness:

28 y/o WM seeking inpt Rx of ETOH use. Employed in insurance traveling, 5 yrs; impaired functioning at work - "doesn't complete responsibilities, Consumes Case beer/day (~~Box~~ cans) last drink 3am; drives while drunk; PWI - 3 yrs ago; Consumed Case/day Age 21-24; D/C consumption but incr 2 lemos ago - related to traveling. Identifies mother stressors; No significant ~~P/O~~ other; Drinks c friends - "all my friends drink." First drink age 9 at Grandfathers house c a cousin; in HS drank every weekend; in 10-12th drank every morning before school; Consumption D/C when got out of athletics - played baseball, martial arts
No current legal problems. Last time tried to quit 2 yrs ago - stayed sober 4 days - resumed "out of boredom". Denies Cravings
No AM drinking, Binge drinker as a teenager No hx of DTs or ETOH withdrawal seizures

Recorded by: Signed PTC Attending Physician:

Mini-Mental Status Examination to be completed? ☐ Yes (If yes, see attached MMSE) ☐ No SCORE:

PATIENT IDENTIFICATION

THE CEDARS HOSPITAL

PSYCHIATRIC EVALUATION FORM

(Complete at time of admission)

PATIENT NAME	LOCATION OF ASSESSMENT	DATE	TIME
Gary McBay	Cedars	6/5/05	

DATE OF BIRTH	AGE	SS#	SEX	MARITAL STATUS	MR#
8/5/76	28	458-95-4195	☒ MALE ☐ FEMALE	☒ S ☐ M ☐ D ☐ S ☐ W	

FAMILY PHYSICIAN	PHONE#	REFERRAL SOURCE

PRECIPITATING EVENT (Why is the patient seeking treatment at this time)

I drink too much

Had gone once before but not ready for help

PRESENTING PROBLEM

Beer tabs going out are $300. Physical condition getting worse not taking care of myself. Daily drinking gets a 30 pk every other day plus what he drinks when he goes out.

Doesn't know how to communicate in life in genera

CURRENT STRESSORS: ~~Financial~~ Job, social skills

# Days Psychiatric problems in last 30 days:	# Days Marital problems in last 30 days:	# Days CD problems in last 30 days:

Previous Diagnosis:	SPN (Special Provider Network):

Current Diagnosis	
Axis I:	Alcohol Dep
Axis II:	Deferred
Axis III:	None
Axis IV:	work
Axis V:	35

PREVIOUS PSYCHIATRIC & CHEMICAL DEPENDENCY TREATMENT HISTORY (Inpatient & Outpatient)

WHERE	DATE	PSYCH OR CD	WHERE	DATE	PSYCH OR CD
none					

Outpatient Psychiatrist	Phone Number
none	
Outpatient Therapist	Phone Number
none	

THE CEDARS HOSPITAL
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DeSoto, Texas 75115
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PATIENT IDENTIFICATION

INTAKE PSYCHOSOCIAL ASSESSMENT

ALCOHOL / DRUG USE (Past & Present) CONTINUED

Ever experienced the following? ☒ Blackouts ☐ Hallucinations ☐ Seizures ☒ Shakes

☒ Overdose When and what: Alcohol Poisoning (his heart stopped)

☐ Other consequences:

Withdrawal symptoms / Behaviors from alcohol or drug use:

☐ Aggressive / Assaultive	☐ Cramps	☐ Agitation	☐ Weakness	☐ Sweats
☒ Change in Blood Pressure	☐ Tingling	☒ Tachycardia	☒ Diarrhea	☒ Fever / Chills
☐ Nausea / Vomiting	☒ Tremors	☐ Irritability	☐ Delirium	☐ Anorexia

If experienced these, when: while drinking "alcohol is like speed to me"

Does the patient have any medical problems that are related to alcohol or drug use? ☐ Yes ☒ No

If yes, list:

What is the longest period of sobriety? 2-3 days When?

Does the patient have a sober support system? ☒ Yes ☐ No If so, who:

AA / NA Involvement: ☒ Yes ☐ No Sponsor: ☐ Yes ☒ No Last contact:

LEGAL HISTORY

Has patient ever been arrested? ☐ Yes ☐ No Number of times arrested: 1 Reason for arrest: on DWI several on PI

Arrests involving violence: ☐ Yes ☐ No If Yes, Explain:

Current or past DWI, DUI, or Public intoxication? ☒ Yes ☐ No If yes, when and why:

Probation (Past or Present): ☒ Yes ☐ No Why and When: served

Parole (Past or Present): ☐ Yes ☒ No Why and When:

Involved in pending litigation / bankruptcy or other proceedings: ☐ Yes ☒ No If Yes, Explain:

SPIRITUAL ASSESSMENT

Religious Preference: christian

Do you believe in a higher power? ☐ Yes ☐ No If yes, who or what do you define as your higher power: God

How do you connect with your higher power and/or feel connected to others?

PSYCHOSOCIAL ASSESSMENT

FAMILY HISTORY:
☐ No psych/chemical dependency history
☐ Mental disorder (Who & What)
☐ Suicide in family (Who & When)
☒ Chemical Dependency (Who) runs in family both sides

FAMILY & SOCIAL:

Number of Marriages: 0 How Long? Current: Previous:

Number of Children: 0 Ages:

CHILDHOOD HISTORY: Describe any milestones;

THE CEDARS HOSPITAL

INTAKE PSYCHOSOCIAL ASSESSMENT

PATIENT IDENTIFICATION

12-71